CALIFORNIA RURAL HEALTH POLICY COUNCIL
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California Rural Health Policy Council
Public Meeting Summary
December 1, 2004 - Sacramento, CA

Council Representatives - present

David Carlisle, M.D., Ph.D., Director
Office of Statewide Health Planning and Development (OSHPD)

Sandra Shewry, M.P.H., M.S.W., Director
Department of Health Services (DHS)

Pablo Rosales, Interim Executive Director
California Rural Health Policy Council (CRHPC)

Morgan Staines, Chief Counsel – representing Kathryn Jett, Director,
Department of Alcohol and Drug Programs (DADP)

Mauricio Leiva, Rural Health Manager – representing Lesley Cummings, Executive Director, Managed Risk Medical Insurance Board (MRMIB)

Maureen McNeil, Head of EMS Division – representing Richard Watson, Interim Director, Emergency Medical Services Authority (EMSA)

Robert Garcia, Chief Deputy Director – representing Stephen Mayberg, Director,
Department of Mental Health (DMH)

Featured speaker
Diane Van Maren, M.P.A., Principal Consultant, State Budget and Fiscal Review

Council Staff
Kathleen Maestas
Kerri Muraki

Meeting commenced: 1:25 p. m.

I. Call to Order - Introductions – Opening Remarks

David Carlisle, M.D., PhD Acting Meeting Chair

II. Department Updates

Mauricio Leiva, Managed Risk Medical Insurance Board (MRMIB)

MRMIB administers the Healthy Families Program which has close to 700,000 children enrolled; the Major Risk Medical Insurance Program (MRMIP) for high risk individuals who cannot access healthcare elsewhere; Access for Infants and Mothers (AIM) which is designed for mothers and infants under the age of two.

Insurance-based Oral Health Demonstration Project
This project was formed in collaboration with the First 5 Children and Families Commission. This three-year $9 M project was funded to reduce the incidences of tooth decay in children from birth to 5 years old. Rural and underserved California has been targeted as areas of greatest need. Some of the projects include mobile dental vans, fluoridations, and other preventative oral healthcare measures. This program has been approved by Centers for Medicare and Medicaid Services (CMS) as Public Health Initiative this will enable MRMIB to serve all children birth to five and not just those in Healthy Families or Medi-Cal. University California at San Francisco (UCSF) will evaluate this project at the end of 2006 to determine project impact and feasibility to contract for ongoing project funding.

Rural Demonstration Project: Request for Proposal, (July 1, 2005 – June 30, 2007) Oral Health Care
New funding cycle –new application
Applications will be submitted through your local health or dental plans, therefore sites should contact their local plans for submittal timelines.
Submission deadline to MRMIB: January 14, 2005.
Contact your plan in your local area or call Mr. Leiva at 916-324-4695 for additional assistance.

Anthem – Wellpoint Merger
Finalized November 30, 2004
MRMIB will receive $5 M a year for 3 yrs and those funds will be used for outreach to increase Healthy Families enrollment.

Morgan Staines, Department of Alcohol and Drug Programs (DADP)

Federal Funds for Alcohol and Drug Prevention Treatment
Virtually all funds are allocated out to the counties for local services. Funding allocation is by county and not by compilation. This allocation process will take into consideration small and rural counties.

Department of Alcohol and Drug Programs (DADP) and California Rural Indian Health Board (CRIHB) Collaborative

Each program independently received a federal grant under the Access to Recovery Program to fund a voucher oriented system for alcohol and drug abuse services. DADP received $22M for three years and CRIHB received about $16M over the same time period. DADP's proposal is not as rural focused, but CRIHB's is. Both agencies are working jointly and using the same vendor for project continuity. CRIHB has not previously been involved in this type of health delivery service or payment program, so through this collaboration they hope to make the process successful. The purpose of the voucher system is to maximize client choice. This is also an opportunity to open up access to faith-based programs which in the past had problems gaining entry and participating in publicly funded systems.

Implementation of Counselor Certification Regulations

In early 2005, DADP will begin an approximate 5-year roll-out, for implementation of specific requirements for alcohol and substance abuse counselors to meet identifiable standards for education and training. Regulations will be administered under DADP purview which will principally, but not exclusively focus on public funded programs. Regulations will also apply to subcontractors that apply for DADP funding.

Statewide, the alcohol and substance abuse counselor shortage is evident. DADP's goal is not to shrink the current workforce, but will be attempting to train counselors currently providing services to meet proposed certification standards. Counselors should be actively engaged in improving their skills while they remain in the workforce.

The implementation process for this regulation was absorbed into existing DADP resources and was done through a hybrid arrangement where DADP will recognize certifications of 8-10 existing private organizations. 'Grandfathered" counselor certifications will only to be recognized by those who are currently certified by these 8-10 entities even if these standards are not based on current regulations. There will be a window of time where "grandfathered" certification will be recognized, but eventually all counselors will have to adhere to the new regulations.

Regulations will allow some test-out for counselors who have been employed in the field for at least five of the last 10 years. The test-out process will enable counselors to receive certification with fewer burdens, rather than to commit to the entire 250 hour coursework process.

DADP recommends that current counselors register with one of the certifying organizations as soon as possible.

For additional information: http://www.adp.ca.gov/lcb/lcbhome.shtml

Robert Garcia, Department of Mental Health (DMH)

Proposition 63

The intent is to get broad input and involvement from all stakeholders. Documents have been posted on DMH's website, www.dmh.ca.gov , in order to communicate and plan our vision throughout the implementation process. A stakeholders meeting is planned for December 17, 2004 in Sacramento. Discussions have been held with CPCA and others on how to allocate funds to small counties, in an effort to encourage them to participate in the planning process. There will be an outreach process in place for groups that are traditionally underserved to ensure that all groups are included.

The website will be continually updated with information regarding the implementation of this program. You are encouraged you to visit it often for further updates. A lot of activity will happen now through April 2005 and continue throughout the year.

Pablo Rosales, California Rural Health Policy Council (CRHPC)

Rural Health Leadership Group

In August 2004, the CRHPC Office convened a Rural Health Leadership Group. This Group pulls together representatives of various rural health advocacy groups, such as: California State Rural Health Association, California Healthcare Association – Rural Health Center, California Primary Care Association, California Institute of Rural Studies, California Legislative Rural Caucus, Association of California Healthcare Districts, CMS – San Francisco Region Office, and the California State Office of Rural Health. The Group focuses and develops positive collaborative efforts for rural health in California. The Group is a platform for sharing ideas, updating issues, rural health program impact, and developing partnerships to work proactively on rural health issues.

The Group strategized and developed proposed language for public comment on the Department of Managed Health Care's (DMHC) proposed regulation for Access to Healthcare Services. Through this effort, Group members forwarded a focused rural health response through their associations. This collaborative effort gave rural health representatives the opportunity to discuss unique rural healthcare issues in California with the DMHC and expect more discussion in the future.

The Group is in discussion to develop a Rural Health Strategic Plan. This plan will be a collaborative effort to prioritize the rural health needs of California.

Rural Definition

The Federal Rural Definitions negatively impact funding sources for California. Pablo Rosales, Interim Executive Director and Scott Christman, GIS Manager of the Office of Statewide Health Planning and Development (OSHPD), delivered a presentation to the American Public Health Association's National Conference in Washington D.C. The graphics and data presented showed the disparities in the Western United States with a

focus on California. The CRHPC Office continues to bring this issue to the forefront with the help of OSHPD, the Leadership Group and other interested stakeholders.

National Health Policy Forum (NHPF) – George Washington University – California's Rural Health Fact Finding Tour

Jessamy Taylor a representative for the National Health Policy Forum (NHPF) met briefly with Pablo Rosales in Washington D.C. to discuss bringing a fact-finding group to California to discuss and observe rural healthcare service issues in California. This is an opportunity to put California's issues on the forefront. On November 30th, the CRHPC Office, the Rural Health Leadership Group and the California State Rural Health Association's Research Group met with Ms. Taylor and Eileen Salinsky, also from NHPF, to discuss the Spring 2005 rural health fact-finding tour. These groups will continue to coordinate efforts for this visit. If you have any issues you think may be pertinent for this fact-finding tour, please contact the Rural Health Policy Council office at 800-237-4492.

Mapping – GIS Capability

Data sets are being developed and refined to better serve the public. The CRHPC Office, in conjunction with OSHPD, is continuing to develop maps at the request of our constituents.

Bi-National Health Week

Executive Director attended a Bi-National Conference in Mexico to address some of the health issues that involve migrant and farm workers. Healthcare and political leaders from Mexico and the United States discussed preventive healthcare measures and will continue dialog regarding group coverage for farm workers who migrant to the United States from Mexico. It also gave OSHPD an outreach opportunity to be involved in community health fairs and visit several locations including migrant camps to promote healthcare careers to children as a career choice.

California Rural Roundtables

Involvement in the regional rural roundtables continues. Development meetings are a continuous resource for constituent feedback, resources and networking opportunities. The second Central Rural Roundtable in Visalia which provided an additional insight on healthcare issues in the Central Valley.

Recruitment for Executive Director of the California Rural Health Policy Council

The recruitment process for the CRHPC Executive Director position is now in process. The posting for this vacancy can be downloaded at http://www.ruralhealth.ca.gov/whatsnew.htm

Free Rural Health Jobs Available Webpage

The Policy Council continues to offer rural health providers national job posting opportunities at no cost. This service is offered in conjunction with the National Rural Recruitment and Retention Network (3R Net). In the last 2 months our office logged

over 130 inquires from health providers across the country interested in working in rural California. These candidates are from various healthcare specialties and are looking for jobs throughout California. The webpage also has links to loan repayment programs, scholarships, and J-1 visa information. For more information, log on to http://www.ruralhealth.ca.gov/jobsavailable.htm

David Carlisle, Office of Statewide Health Planning and Development (OSHPD)

Cal Mortgage Loan Insurance Program
This program allows not-for-profit and governmental entities to apply for insurance to support capital expansion financing. This program is becoming more competitive with the private sector. The current portfolio stands at approximately 1 billion dollars of insured loans and a potential portfolio of $3 B. For additional information on the Cal Mortgage Program, look at our website at http://www.oshpd.ca.gov/oshpdKEY/LoanInsurance.htm

Discharge Data Collection
Emergency department discharge data and ambulatory surgery discharge data will be added to OSHPD's hospital dataset. Hospital data is available six months after the reporting period, at www.oshpd.ca.gov. First quarter data for ambulatory surgery and emergency data is expected to be available mid 2005.

Chargemaster Legislation
This legislation came about due to hospital charges and billing practices that occurred in the past 12 – 24 months. OSHPD is in the process of generating regulations to facilitate the collection of Chargemasters and this process should be activated by mid 2005. For additional information, go to http://www.oshpd.ca.gov/hid/hospital/chrgmster/index.htm

Maureen McNeil, Emergency Medical Services Authority

EMT II Regulations – Intermediate Level for Pre-hospital Care Personnel
Regulations expect to undergo two-year revision process. EMT II's are utilized primarily in rural areas. A modular training which will allow flexibility of training is being considered. Training for the full scope of practice will not be required. Focus will be training at the basic level, with add-on modules pertinent to the area of specific need. It is viewed as an improvement of services for rural areas.

Sandra Shewry, Department of Health Services (DHS)

Bi-National Border Health Commission
Member of the Commission representing the State of California.
Mexico partners are very interested in patients with addictions and substance abuse.
The United States partners are very interested in patients with infectious disease and bio-terrorism preparedness.

Cal RX
The Governor vetoed bills allowing Canadian drug availability for California. Bills were vetoed on the belief that this was not a sustainable path for low income or uninsured Californians, citing Federal laws regarding the importation of drugs. Imported drugs require Food and Drug Administration (FDA) certification for drug safety and the FDA was not confident of their capacity to certify all needed drugs involved in this bill. Cal RX is in response to the veto message. The Governor wants to develop a program for low-income uninsured Californians that did not involve an importation program. Discussions are ongoing with manufacturers to voluntarily participate in a structured discount program. DHS continues looking at all options.

Nurse-Patient Staffing Ratios
Current nurse ratios will stay in effect. California is the only state in the nation that has nurse staffing ratios in every unit of the hospital. The administration absolutely supports these ratios. Emergency regulations were filed to delay the enhancement of the ratios. This was done due to the nursing shortage and to some of the consequences that will involve the enhanced ratios. This is not a stepping back point, but will continue to address the workforce shortage issues. For additional information, go to http://www.dhs.ca.gov/lnc/ntp/default.htm

Bio-terrorism Preparedness
State continues to try to acquire funds for our county partners. For additional information, go to http://www.dhs.ca.gov/ps/ddwem/environmental/epo/epoindex.htm

Business practices
Director comes from a small agency of 60, and now at DHS with a staff of 6,000. Business practices can be improved. This year's priority is contracts. The goal is to have all current year contracts started in July 1, 2004 to be signed by the end of this calendar year. It's unconceivable that some vendors have to wait to almost the end of the fiscal year to have contracts executed. It is a function of workload and culture and DHS is trying to change that.

Obesity - Tobacco Health Summit
Mission is to improve the health status of Californians. Obesity and tobacco use had a [illegible]e impact on disability and death of Californians. In response to this DHS will be [illegible]ing a summit on those topics in January 2005. Additional information can be attained at
http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/cms/informationnotices/2004/cmsin0406flier.pdf

III. Featured Presentation – MediCal Redesign in California

Sandra Shewry, M.P.H., M.S.W., Director, Department of Health Services

The Department of Health Services has been working on this initiative for the last 9-10 months. The purpose is to reduce the State General Fund cost for Medi-Cal which was $3 Billion between 1999 – 2004. During that same period, enrollment increased by 1.7 million people. Medi-Cal is the third largest expenditure in the state budget.

Administration's Medi-Cal Re-design rules:

- Maintain the eligibility for current program enrollees
- Contain cost and maximize efficiency

Twenty-two stakeholder meetings were held for public input. Some issues reviewed by stakeholders and the legislature required more in depth study and discussion. The study will released with the Budget on January 10, 2005.

DHS is looking at organized systems of care. In other words, in terms of health outcomes, delivery systems do matter, it's varied in terms of accountability, and for the state it is better when practitioners practice in groups.
For additional information, go to: http://www.dhs.ca.gov/medi-cal%20reform/default.htm

Expansion of the use of Managed Care
It is believed that managed care can be provided statewide to people who use Medi-Cal. Rural managed care will be a different model than that currently used in urban California, where the idea of competing plans makes sense since you have a high volume of potential membership. West Virginia uses a model that is called Rural Provider Option, where they hire someone to manage their fee-for-service program. This will expedite TAR approval and provider enrollment. This model automates the program to bring fees back to the providers.

There are women, children and families with children currently enrolled in managed care in California. Eight counties have county organized health systems that include families, women, children, seniors and people with disabilities in managed health care.

Enrollment
A cost saving possibility is to have counties access some of the tools of more recently designed programs, like Healthy Families who use automation effectively. This program has call in lines that are staffed in different languages, mail-in applications, the ability to utilize customer feedback, maximize staff resources, etc. The CPR is recommending switching the entire eligibility system over to these kinds of mechanisms. DHS is currently looking at the pros and cons of making automated eligibility improvements to the system. All 58 counties will be impacted as to where people will go for information, as well as jobs in those counties.

Benefits

California is one of 10 larger states in the nation that provide most of the optional benefits that Medi-Cal offers. Most governors proposed benefit reductions across the board. The across the board reductions do not work in Medi-Cal.

- Should benefits provided to parents, be the same benefits as those provided to seniors or the disabled?
- Is it possible to align benefits, more like it is in the private sector?

A program that is easy to defend to policy makers and the public is needed. One perception frequently hears is, "Medi-Cal pays more benefits than my employer provided health plan." For instance, Medi-Cal pays for some over-the-counter drugs. One of the factors in benefit changes is that it may cost you more for over-the-counter drugs if doctors are asked to fill out scripts for aspirin, vitamins, etc. This also increases the possibility for the doctors to then write a script for antibiotics at a later date, thus increasing cost.

Cost Sharing

Three ways to view cost sharing: Deductibles, premiums, or co-payments. Shared-cost, a form of deductible, and co-pays are required for and currently exist in Medi-Cal. Premiums do exist in very small areas in Medi-Cal for the disabled who meet specific eligibility requirements. They also exist in the AIM program for Healthy Families.

The state of Oregon used premiums ineffectively and the system charged people who had zero percent of income. Alternatives are being sought where there can be income sensitivity for the idea of premiums. Premium collection requires an infrastructure and that will incur cost.

Interest in managed care is thwarted by current federal financing rules. These current rules adversely impact public hospitals reimbursements. These rules create an incentive for overnight stays for Medi-Cal in the fee-for-service system and are in conflict with cost-effective managed care practices where most patients can be treated on an out-patient basis. There is a need to figure out a more effective financing mechanism to work with the federal government that doesn't destabilize our Disproportionate Share Hospital (DSH) and safety net hospitals.

The governor asked that there be no new taxes and the new LAO report stated a $8 Billion budget year shortfall; therefore, all of the fore mentioned methods may not be implemented. Using Medi-Cal managed care more globally requires investment. These ideas may not save money in year one, but they may save money in the long run. These methods have not been adopted by the administration and may change prior to the January 10th release. These are proposed ideas that will hopefully make the program more sustainable.

Diane Van Maren, M.P.A., Principal Consultant, Senate Budget and Fiscal Review

Budget process
Testify effectively; work within your associations; this does make a difference.
There will be some restructuring of committees in 2005: Insurance, Health and Human Services Committee will be split with Senator Ortiz retaining her chairmanship over healthcare issues. Senator Chesboro will retain his chairmanship for the overall Senate Budget and Fiscal Review.

Subcommittees are formed to gather information in detail as staff goes through the budget process. This will allow us to appropriate funds more effectively through detail, public comment and thorough study.

Health and Human Services – Subcommittee 3:
Chair – Denise Ducheny (D) San Diego
http://www.senate.ca.gov/~newsen/committees/Sub.htp

It is critical to be involved in the subcommittee process. This is where the key building blocks are made for budget negotiations. This subcommittee gives you an opportunity for public comment. Mondays, starting the first week in March, will principally discuss health issues and Thursdays the discussion topic will be drug/ alcohol, social services, foster care, etc. Participation in this process is encouraged. For updates, go to the Senate Daily File web page at http://www.senate.ca.gov/~newsen/schedules/files.htp

Each bill must appear in the http://www.senate.ca.gov/~newsen/schedules/files.htp for four days prior to being heard in a committee. The Daily File is the agenda of the day's business, together with public notice of bills set for committee hearings. By checking the File, you can keep track of bills that are being scheduled for committee. If you live out of town and plan to testify at the hearing, it is a good idea to call the author or your legislator to make sure that the bill is going to be heard on that date. Sometimes bills are taken off the agenda at the last moment.

A schedule will be released in approximately the first part of February to let you know what being heard when.

This is your only opportunity to present public comment through the subcommittee process. When you get into the Budget Conference Committee process, only the Legislative Analyst Office (LAO) and Finance are involved. Public Hearings will be held but the public will not be asked for comment at that point.

If you can't publicly participate, send written testimony or work through your associations.

LAO 2004-05 Fiscal Outlook Reports
The LAO, which came out November 2004, identifies a structural deficit. Based upon current law, state is spending more than it is bringing in. For more information, go to the LAO webpage at: http://www.lao.ca.gov/2004/fiscal_outlook/fiscal_outlook_04.pdf

Staff reviews and analyzes this report in subcommittee and continues to gather additional information and public comment. Staff will then produce a "red book" which is an initial publication that is available on our website.

At the end of February, the beginning of March another publication will be released from the LAO office on issues – An overview of State Expenditures. This will also be available on their website www.lao.ca.gov

Federal Funding
California does not get its fair share of federal funding. This is evident through a myriad of programs. Washington is being made aware and this office is currently working with the Governor's office to see what can be done with respect to President Bush. California has always been under funded and it's unlikely that this situation will be remedied in the near future. This should be kept in mind regarding Medi-Cal Redesign and obtaining federal waiver (1115 Medi-Cal waiver).

Kaiser Statistics
California has 18% uninsured vs. National average - 15%
California has lower rates of employer based health insurance coverage 52% vs. 56% nationally
1 in 5 Californians are compensated through Medicaid.

Medi-Cal Eligibility
Approximately 178 eligibility codes at the county level
1200 page eligibility manual
Currently too complex – the process needs to be simplified

Budget Impact
Medi-Cal: 14 – 15% General Fund revenue.
California's spending per capita is one of the lowest in the nation.
Medi-Cal regulations and access to services need to be improved to increase per capita allotment.

Cost Containment
Legislative cost containment is still pending full implementation by the Department of Health Services. The status of the implementation will be reviewed in January when the budget is released.

Follow-up and fully implement already approved regulations and legislation prior to making additional changes to the system is necessary. If Medi-cal continues to be a

patchwork program, this will leave a much more complex program that makes it even more difficult for individuals to know what services they are eligible for, where to get them; and for providers, how to get reimbursed and plan for the future.

Federal 1115 Waiver for Medi-Cal Re-Design
http://www.cms.hhs.gov/medicaid/1115/default.asp

- Federal government most likely will be resistant to any waiver.
- Waiver must be cost neutral for 5 years.

Public Comment on Medi-Cal Re-design

Kurt Hahn – Director, North Sonoma County District Hospital
I have observed in Sonoma County, there are more young drug addicts or ex-drug addicts who are filing for Medi-Cal disability than any seniors filing for Medi-Cal. Disabled is a category that is abused and eligibility standards need to be toughened up. Computers should be in every senior center in the state to make it easier for seniors to sign-up for services. I believe this was recently a pilot project in some areas of the state. Most of the elderly, who now go to the county office, even though staff may be helpful, are intimidated by the social workers or the general environment of the office, so eligibility paperwork is not completed.

Sherwry response:
Even though most Medi-Cal recipients are women and children, most of the costs are associated with the smaller proportion of recipients, which are the elderly and people with disabilities.

The definition of disabled is not one thing. There are people with physical, developmental and mental health disabilities. The rules about qualifying for disability cash grants are driven by federal government and those rules were revisited in the last decade. So now more people with substance abuse related issues are getting on the disability program. This is one of the few big social policy conundrums that don't fall to my department.

We believe the mentally disabled are often lost to the system. Giving a mentally disabled person a Medi-Cal card and telling them to look for services doesn't always work. The managed care system will have to look different for a person with a mental health disability. We think we can better serve the mentally disabled and the taxpayer if we have some management of care and provide services that can improve their lives, rather than have them turn to emergency rooms.

In San Diego, Healthy Families did a computer pilot for children to fill-out health e-app. Several counties are trying to embrace these practices for their entire Medi-Cal population. It is definitely something that we at the State want to push. It is rolling out first to families and children, because the people that tend to have assets are those who are older and a bit more established. These populations are often those in the disability

category, not necessarily those with substance abuse, but those with chronic disease. We are looking at more automation; ways to make it easier. We are asking why the client just can't go on-line and fill out an application. Even with an e-app you have to be served by an application assistant for access to the system. Other states have access over the phone.

Woody J Laughnan, Jr, Administrator, Glenn Medical Center in Willows, CA
Would like careful consideration of the managed care system for rural California and how it will impact Critical Access Hospitals and the safety net health systems.

Van Maren response:
Senator Chesboro is a strong advocate for community based clinic services, especially since they give you a big bang for your buck. Clinics services are a healthcare mainstay throughout California. We have worked very hard through the budget process to assure the Prospective Payment System (PPS) is distributed fairly through CPCA and other health associations. Rural Hospitals are vitally important in rural areas. Managed health plans don't seem to work in rural populations. With the low populations, I don't see how managed care can work all that well in rural areas, especially with more involved populations. These issues will definitely be on the radar screen as we get underway.

Mary Huttner, California Healthcare Association – Rural Healthcare Center
I would like to applaud DHS for their efforts in trying to utilize managed care services to increase efficiency and trying to increase outreach in other areas in government.

When the 2-plan model for managed care was implemented, the rural areas primarily had access carve-outs. If the current urban model is used, the inpatient utilization rates will not cover costs in rural areas.

The fee-for-service program cost is very large. The Sonoma model did not work and it needs to be reviewed to see what aspects were successful and what went wrong. What questions were not asked upfront? This was a progressive yet complicated model. Look at adjunctive support like tele-health. Review the store-forward issue in regard to tele-health, it would be beneficial. Look at what makes sense for rural healthcare; keep the dialog open to rural providers. Communication on rural issues currently does not exist within the departments with the exception of the Policy Council. The government bureaucracy is especially tough for rural providers who have limited staff and don't have time to talk to several departments or divisions of Health Services to have a question answered.

We hope to continue dialog on rural issues and I know CHA is very interested in keeping this communication link open.

Public Comment - General

Carol Mordhorst, Public Health Director of Mendocino County
Chair of CMSP Governing Board

You have seen me at two previous hearings and you will continue to see me at hearings until we get resolution on this Healthy Families / Alcohol and Drug issue. Unfortunately, in your outcomes paper you give yourself more credit than you deserve on this issue. I was part of that committee and there has been no progress on the MOU regarding this issue since Bud Lee left. This particular issue involves Health Families plans are not providing drug/alcohol services to adolescents. The judicial system refers them to the county health system or the clinic and does not provide us with compensation. Plans are the ones that are paid to provide this service and they are not providing it. They are unwilling to contract with us to do it. My feeling is that MRMIB should not be paying the plans to do this, there should be a carve-out because these kids are our future, and especially in rural areas the adolescent drug and alcohol issue is phenomenal. We have to get going on this issue and we need to get it resolved.

Medi-Cal Reform – Our county is currently in a variable pay fee-for-service system with the exception of a PPS system for the clinics. Now that we are talking about the 1115 waiver that is capped, my fear is the rural areas are going to be the last ones to get to the table. We are going to be dealing with capped Medi-Cal payment and without recognizing that these providers are currently really low paid and caps on these counties where managed care is a real concern. After ten years, the state realized that they started with an easier population, and now has only expanded to the aged, blind and disabled. To think that you are going to serve all those populations simultaneously in a rural area, I am very concerned that you would jeopardize our entire already weak health delivery system. This is the same delivery system that I personally rely on for my healthcare through the county; that our school district employees rely on. This could be the straw that breaks the camel's back.

You need to provide incentives for the plans to contract with the local providers. I have been contacted by come of your existing health plans that tell me that they have been in conversations with the Department of Health Services and that DHS wants to expand into our county. Why doesn't the Department of Health Services contact me or any of the hospitals or clinics in our county and see what we want. We don't want another county to decide what is best for our county. If a county managed care program that has an urban mentality and has no clue about what it's like to work in a rural area and suddenly wants to expand into Mendocino County and impose on us on what they have already done in Alameda County, will not work. If these health plans want to expand into our counties, we think we should have representation on their governance boards. Whether they are a county organized health system or whoever, we want to have input. We don't want this to be something that is done to us, but with us.

Greta Elliott, Camby Family Practice Clinic

A client in my care is having difficulty getting through the Healthy Families process. The scenario: He first applied for Healthy Families in May 2004, and was told there would be a 2 weeks application process. After 2 two weeks I called and was told the application was in process. I called a week later and they said the address was missing. I faxed the information, and then called a couple of days later. Healthy Families said they never got my fax, so, I mailed the address information. I called Healthy Families again a few days later and they said, "We have the forwarding address, since the applicant lives 2 ½ miles from the Oregon border the computer can't accept that address." I referenced them to a map that the address was actually in California and called Davis Creek that was about 20 miles away and got an address in Davis Creek to get the California address that can be used in their system. This client has two children with extreme dental needs. When they came into our clinic in May, it was recommended that they sign up for Healthy Families. By this time it's September and one of his daughter's turned 19. The next time Healthy Families called, they said the application income information was too old. So, we sent them current copies and finally they said since the oldest daughter turned 19 and she didn't qualify and the other daughter had a missing address. Now we are into October, and my client actually sent State Assemblyman Doug La Malfa a scenario letter, and still hasn't received any answers. This is just one story; I could give you a lot more. I am asking is there a way that we get can help, a contact, something we can do to help with these kinds of problems. This man wrote this up for me and asked me to help him in any way. We at the clinic have provided his daughters with dental care and he is paying back $30.00 per month to cover the cost.

Leiva response:

I think there is something we can do and I'd like to speak with you after the meeting and I'd also like to speak with Carol regarding her Healthy Family issue.

Herrmann Spetzler, Open Door Community Health Centers

I appreciate this opportunity to speak to all of you at the same time, and I hope that we don't lose the Rural Health Policy Council because it gives health care providers, like me, a valuable forum for speaking simultaneously to the various state government branches concerned with rural health issues.

I would like to address what is referred to as the "four walls" issue. This is a state ruling that prevents community health centers from billing for services unless they are provided within the "four walls" of their own clinic buildings.

My concern is that the four walls limitation is costing the state considerable money and putting the safety net in jeopardy. The restriction of the four walls ruling prevents access to health care in three areas: medical specialist services, mental health services, and services to hospitalized and institutionalized patients.

<u>The four walls rule prevents access to medical specialists</u>

In our area -- the far north coast of California -- we have very few medical specialists, such as orthopedists and psychiatrists. Almost none of the specialists we do have will accept patients on public reimbursement programs such as Medi-Cal and CMSP because the reimbursement rate from these programs is so low. Our clinics, as Federally Qualified Health Centers, receive a reasonable reimbursement for these patients. However, it is not feasible for us to employ the full range of medical specialists full time on our staff because of the limited number of our patients needing these services.

The logical solution is for me to contract with the specialists to provide services to our patients for which we would be reimbursed at our rate. The problem is that our clinics do not have the physical space necessary for these specialists to practice within our four walls, nor do we have funds to duplicate all of the specialized equipment such specialists need.

Obviously it would better serve out patients to be able to receive these services in the medical offices in which these specialists already practice.

Unfortunately, the current lack of access to specialists results in patients ending up in emergency rooms, being admitted to our hospitals and often transferred out of our area at extreme cost.

<u>The four walls rule prevents access to mental health services</u>

The mental health service system in this state is broken and it has been broken for a long time.

Our staff is overwhelmed by patients needing mental health services unavailable elsewhere. The eight Open Door Community Health Centers clinics employ 5 mental health providers among the 61 medical providers on staff. Our clinics see about 550 patients a day, of which 50 of them are in mental health crises, and about another 100 have other mental illnesses. Obviously there is a much greater need for mental health care than we can provide.

Yet private mental health providers don't want to treat our patients because of the low reimbursement rates. For example, a child psychiatrist would possibly be willing to see some of our patients, but is not willing to get paid through the Medi-Cal system. The result is that we have family practice doctors seeing patients who are having mental health crises, and trying to manage patients with poly-drug regimens that the family doctors are not trained for or comfortable with treating.

The solution is for the Open Door to contract with local mental health providers to see our patients in their offices, for which we would be reimbursed at our FQHC Medi-Cal rate. This solution is not an option due to the four walls rule.

This means that patients who have untreated mental health problems end up in severe crises at our emergency rooms or jails – both of which are expensive and ineffective in treating the mentally ill.

<u>The four walls rule could prevent clinic doctors from treating hospitalized and institutionalized patients</u>

In the last year we have become the sole health care provider in a 100 mile area willing to take hospital call – that is, willing to admit and treat non-Indian patients in the local hospitals. Currently we provide services to our patients in hospitals and other institutions and bill for the services just as if these patients were being seen in the clinic. However, discussions of the applicability of the four walls rule to hospitalized patients puts the future of this service in jeopardy.

The application of the four walls rule to hospitalized and institutionalized patients would devastate our OB program. It would also destroy the continuity of care for all other patients when they enter residential treatment facilities for mental illness or substance abuse or reside in facilities for the developmentally or physically disabled or in nursing homes for the elderly. In short, this application of the four walls rule would force us to abandon our patients whenever they leave our building and whenever they are physically unable to come into the clinic for care. Yet, there are no other providers in northern California who are willing or able to see these patients.

Conclusion

These are some very serious real issues, not only for the Open Door Community Health Centers, but for all community clinics in rural California. If the four walls rule is not repealed or suspended we will have a real crisis on our hands.

I merely suggest that we re-look at the rule as it applies to rural clinics. I understand the concern that the State has in repealing the fours walls rule in urban areas, because of the negative impact it might have on the private sector. But I can assure you that in rural areas there is no private sector for Medi-Cal patients, and if you want those patients to be able to get access as close to home as possible, you have to look at other alternatives to the four walls limitation. The alternatives in place right now -- the emergency rooms, the jails, or deferring care -- are very expensive.

Judith Shaplin, Mountain Health and Community Services

I would like to echo Herrmann that the Four Walls issue is a huge problem for rural in trying to get access to our care. When we talk of managed healthcare, I do have some questions on the timeline for the PPS reconciliation rate status that went into effect in January 2001. We are a very small RHC that was converted to a 330 two years ago and we are still under RHC reimbursement because of a multitude of changes; forms to be done, changed policy to be done, but the wrap-around, where we got reconciled, which means the health plans actually paid us and we are at PPS rates. We are a small rural health 330; I am currently waiting for payment to up to $165,000. That is a huge amount of money for us. It has been delayed because we have been through multiple, multiple copies of drafts “is the form right; is this form not right.” For several years the Department of Health Services has not being able to make a decision of what was right. We are accountable to very strict guidelines and timelines, if you miss a deadline, then you are out. We have submitted it, re-submitted it, and re-submitted it and this has been since June. It is now December we have not heard anything. Is this the expected numbers, what is going on with the numbers? Truthfully, we would like a check.

I am like many clinics, RHC's, 330s . . . We just want some response. You have said Dr. Shewry that you were willing to work with us and make things work in the Department, we applaud that. We will come in and help you. We need to work with your Department and not feel that we are being worked over and that is sometimes how we feel.

Kurt Hahn – Director, North Sonoma County District Hospital
I applaud you for giving us the opportunity to talk to you all at the same time. CalPers has a rural taskforce dealing with rural healthcare issues that apply to all state employees, state retirees who live in rural areas and their access and the quality of care they are able to receive. This also includes those who contract with CalPers who receive their healthcare insurance. Your Council should be involved with them.

I think it is ridiculous that our prisons buy drugs from one party, the University of California and its hospitals buy it from somebody else, Health Services for Medi-Cal contracts buys it elsewhere and we do not have a direct purchasing pool that encompasses all the purchasing power of all segments in California including public entities like public hospitals. I know there are many states that are doing different things that have dramatically cut cost. The CalPers sponsored legislation should be part of the Cal RX discussion.

We have heard that there is a $1B backlog in OSHPD new construction waiting for approval. I can tell you that delays cost construction dollars and they can get projects unfunded after they were originally funded. This backlog can create a lot of new jobs for California. If we got the Governor's attention to do whatever it took to make those approvals happen, this could positively impact the local economies. From the standpoint of the providers, this would avoid the situation of projects of what we thought was funded, and what is no longer funded because of price appreciation or escalation at a current high rates. This is a serious concern for hospitals and clinics. If that backlog can get cranked out, I'm sure the Governor will approve more staff and the local providers can get things built.

Response Shewry:
I just wanted to go over some of the comments that were raised that related to the Department of Health Services. I heard some people express concern that maybe we were thinking the rates in managed care for seniors and the disabled would be the same rates that we would be paying for families and children. We understand that it is much more expensive to handle the healthcare needs of a person with a serious healthcare burden which is often the case and that is why the person will qualify for the program. We are looking at those costs as they relate to those population groups. We have a fabulous database which is call the fee-for-service program. We know the utilization and the trends. We have a very rich amount of information by what we call aid code or major groups. I heard that at a couple of meetings and people think maybe we are just going to pay the kid rate, but that would not be right.

On telemedicine, the Kuehl bill, that was vetoed. We wanted to support that bill, but we couldn't wrap our minds around store-forward, where the specialist isn't there on-line. We were concerned on how that bill was constructed, that it appeared to establish a basis that Medi-Cal would have to reimburse for a face-to-face encounter based on that store-forward. We aren't trying to get in they way of making it easier to use store-forward, we think it makes sense, but we are not going to pay the same amount we are going to pay in real time and the specialist is there and can talk to the patient or when the patient actually goes. We need to work that out and the reimbursement needs to be different. We like the idea of the bill, we like telemedicine, we think it makes sense and has a lot of applications.

The Four Walls issue, I got the sense that there are many of you that are interested in that and we should have a meeting on it. I'm not sure that I can give a good description of what the Four Walls issue is and I apologize for that and I would like to learn more about that, because that seems to be a concern for many of you.

We seem to owe some of you money for the wrap-around on the difference between the health plan and the clinic rate; we need to look into that. Often when we look into it, it is maybe one of our instructions has made it that you will always submit the form wrong and it was just an error, we can work that out. I would be happy to have a meeting on that. I don't know who I am looking at for conveners for these meetings, and obvious focus is through the clinic associations, or something.

Regarding Cal RX, one of the alternatives is Canada, where there is a discount program which is the path we are on. One of the alternatives is Medicaid. The states of Vermont and Maine have both tried to say the best prices are those they get through Medicaid. The Federal government wouldn't approve those waivers, actually one case went to the Supreme Court. It's not possible today to have a purchasing pool with us. For Medi-Cal we are getting such big discounts, what we are doing is getting emulated in some of these multi-state purchasing pools, because the rebates are getting so big. The State is taking steps through the Department of General Services on just the idea you were talking about for buying for other entities. Medicaid has this safe harbor in federal law that manufacturers can give us discounts that are not willing to give anyone else, except the VA and the 340B program is very good and we need to be sure that is being used as much as it can be used.

Chairman Carlisle:
Due to time constraints we will have to adjourn the meeting. For those of you who would like to make public comment, I encourage you to do so in writing and the contact information for the Council office appears at the top of your agenda so you can forward them to us directly or give them to us directly.

Meeting adjourned: 3:25 p.m.

Written Testimony
Testimony as written on testimony card at the Rural Health Policy Council's December 1, 2004 Public Meeting. Follow-up was made with constituent to affirm statement accuracy for submission:

MiLorene Jefferson, RN
Vice President, Board of Directors; Shingletown Medical Center
530-474-3774

The Department of Health Services (DHS) - Nurse to patent staff ratios are mandated but yet we have a nursing shortage and a present and rising aging population in the field of nursing. Is it feasible to have a DHS State Taskforce to explore ways to attract nurses, i.e. lowering visa requirements for foreign nurses, raising enrollment of nursing students, increasing State or Federal funding of students, student loans cancelled after x number of years of service in rural areas, lots of ideas and potential to be explored, including a clause to prevent a large urban organization buying out a contract from a sponsoring small agency for a foreign nurse. Catch 22 – nurse/patient. Hospitals cannot meet mandated ratios, because of shortage or a great increase of cost by using traveling nurses or private agencies.

Testimony as written on testimony cards at the Rural Health Policy Council's December 1, 2004 Public Meeting.

Clara Miranda, Delano Women's Medical Clinic
661-721-5760

Medi-Cal provider numbers and the approval process. Four applications submitted:
1 change of address – submitted 10/03
1 preferred status application submitted 6/04
2 applications submitted for new Medi-Cal numbers. One in 01/04 and 08/04.
To date these applications have not been approved.

Raymond Hino
Chief Executive Officer, Tehachapi Valley Healthcare District
661-823-3001

In my experience as a rural hospital CEO, managed care does not work in rural areas. The effect is health plans sell their HMO products to rural residents and then completely ignore local rural providers (hospitals and in some cases, doctors as well.) How can we make the health plans, including Medi-Cal, managed care plans responsive to their members (e.g. covered lives) by providing access to local healthcare services and by not requiring members (e.g. covered lives) to travel 50 miles or further for basic and preventative health services (routine blood tests, mammograms, x-rays.) This is a disservice to covered lives and a service blow to small rural hospitals that are routinely bypassed.

Gloria Grijavala
Community Relations Coordinator, Community Medical Centers
559-459-2938

There are about eleven states that receive reimbursement for providing interpreter services even though California is one of the most diverse, we are not able to receive reimbursements. Is there anything anyone is looking at? Title VI requires interpreter services.

Jennifer Lind
UC Berkley Graduate Student
jenlind@berkley.edu

How will Medicare Part D claw backs impact the commitment to maintaining Medi-Cal eligibility?

Beth Hart
Hart Consulting
916-442-0167

Role of schools in rural health and social services. Schools are often the door to services or the only provider in rural and frontier communities. School-based family resource centers and before and after school programs work collaboratively to get services to low-income, immigrant, farm worker, chronic poverty, special needs and homeless families. Would you consider an education representative on your Council?

Other written testimony submitted attached.

CALIFORNIA STATE
RURAL HEALTH
ASSOCIATION

Committed to preserving and enhancing health in rural California

California State Rural Health Association

Testimony to the Rural Health Policy Council

December 1, 2004

The California State Rural Health Association (CSRHA) thanks you for being here and for this forum to share our concerns.

First CSRHA would like to recognize the RHPC for listening to our concerns and for responding to our requests in 2004. We provided testimony to you in May 2004 regarding the future focus of the Rural Health Policy Council and also have requested assistance with a number of issues throughout the year. Your leadership and partnership are greatly appreciated. CSRHA urges the RHPC to continue to increase the visibility of rural health issues in California.

Today, CSRHA would like to share areas where your help has been invaluable, and to continue to ask for assistance:

First, CSRHA requested your help with addressing issues related to the federal definition of rural areas, called Rural Urban Commuting Areas (RUCA). Thank you for assisting with developing a policy brief on this subject. We also thank you for your leadership and support in completing the Medical Service Study Areas (MSSA) reconfiguration with 2000 census data, and for advocating to the federal government for an exemption for the RUCA definition in California, instead using the MSSA definition. We have met with Dr. Marcia Brand, Director of Federal Office of Rural Health Policy and Dr. Betty Duke, the Health Services Resource Administration (HRSA) Administrator on this issue. While we have received a response from both policy makers, it still has not fully addressed our concerns.

We request assistance from the RHPC to secure support and assistance from Governor Schwarzenegger and Kim Belshe, the California Secretary of Health and Human Services (CHHS), advocating for the MSSA definition.

Secondly, CSRHA requested your help last year to support funding for federal programs at levels recommended by our national organization, the National Rural Health Association (NRHA). We appreciate your letters of support on these critical programs, including National Health Service Corps, health professions programs for nursing and other midlevel programs, the Critical Access Hospital program, Federal Office of Rural Health Policy Network and Outreach Grants, telemedicine and many more. Your letters of support were instrumental in ensuring funding levels for programs administered by the Federal Office of Rural Health Policy were restored by Congress in 2004.

CSRHA will be submitting to the RHPC its recommendations again this year for rural health federal funding levels, and will request your letters of support.

- Third, CSRHA requested your help and assistance with data collection and mapping services to support the workforce diversity report, a project that was funded by The California Wellness Foundation. Due to RHPC and Office of Statewide Health Planning and Development (OSHPD) staff expertise and Geographical Information Systems (GIS) we were able to provide more than 50 maps describing rural California's demographics and other information. These products are helpful to rural communities in describing their areas in greater detail to apply for federal and state funding and to advocate for California's rural populations.

  In 2005, CSRHA requests the RHPC assist us in developing maps of healthcare resources throughout rural California to be utilized for advancing technology infrastructure.

- Fourth, CSRHA requested your assistance in assuring state funding for rural health programs to be maintained, and to work with CSRHA to evaluate the state budget and its impact on rural health care in California. To ensure the health of our rural communities, we need to continue to advocate for rural health funding in the state budget.

  In 2005, CSRHA requests the RHPC focus attention on the state budget (especially proposal to restructure Medi-Cal and to implement the recommendations of the California Performance Review) as it relates to rural health in California. We request the RHPC convene a special meeting to accept testimony on the impact of the Governor's proposed budget and other major proposals, and to present this testimony in a report to the Administration and to State Legislators.

- And finally, the Governor vetoed AB 2281, legislation sponsored by CSRHA to enhance the role of the RHPC.

  CSRHA reiterates the need for an effective and viable entity at the state level with the authority to coordinate activities and advocate for change on behalf of rural health in California. We request the most recent annual report required by legislation to the State Legislature be released immediately. CSRHA also offers to work with you on future reports.

Thank you and we look forward to continue to work with you to advance rural health in California..

December 1, 2004

Rural Health Policy Council
Sacramento, California

To Whom It May Concern:

Central California Dental Surgicenter has been an outstanding venture for Castle Family Health Centers and its partner Larry Church, DDS. More importantly it has provided a remarkable service to the children and developmentally disabled of our area. Our reputation is outstanding.

In a state where less than 2% of Medi-Cal children from birth to twelve years of age receive any dental care we have treated over 14,000 cases. Because of severe dental problems these children cannot be treated in a conventional dental office.

Castle Family Health Centers is planning to join another facility in the Central Valley to construct a dental surgicenter. Not only will it provide dental care to the Medi-Cal children but will provide financial benefits to an acute care hospital that is struggling to survive.

As we will invest a large sum to start this new center, we need to know that it will be surveyed in a reasonable time period after completion. If the project is not reviewed for six months to a year or more then we may not be able to go forward.

For the sake of our Medi-Cal children we ask that when we are ready DHS find a way to review this center and other like centers that may soon be built throughout California.

Sincerely,

L Ned Miller

L. Ned Miller, MBA, FACHE
Chief Executive Officer

LNM/fc

CASTLE • 3605 Hospital Road, Suite H • Atwater, California 95301 • (209) 381-2000 • (209) 722-9020 FAX
ATWATER • 1251 Grove Avenue • Atwater, California 95301 • (209) 358-8425
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CCDS

CENTRAL CALIFORNIA DENTAL SURGICENTER

November 11, 2004

L. Ned Miller
Chief Executive Officer
Castle Family Health Centers
3605 Hospital Road, Suite H
Atwater, CA 95301

Dear Ned:

I understand that you are going to attend the California State Rural Health Association meeting and will speak to the Rural Health Policy Council. Perhaps you can help me.

I am building a dental ASC in Indio, which has always been a dream of mine. The surgery center will be located kitty corner to JFK Hospital on Dr. Carreon Drive and Monroe. The surgery center will have three OR's and is approximately 7000 square feet. The cost of the project is around two million dollars. We acquired the property last year and construction should start within two months.

When we opened Central California Dental Surgicenter it took approximately six months to get surveyed so we could treat Medi-Cal and Healthy Families patients. Now I am told that it may take at least a year to get surveyed after we are turn-key, are fully staffed and have our certification of occupancy.

This creates two problems. First, I do not know if I can financially survive a year without any revenue. The second issue is that I treat mostly underserved children from one to seven years old. I am sure you have much better demographics than I have but as of December of 2003 there were 42,000 Healthy Families patients in Riverside County and 254,000 total Medi-Cal patients. I only treat pediatric patients who cannot be treated in a conventional dental setting. I accept what Denti-Cal pays; which for the facility fee is 10 percent of the usual and customary fee. Denti-Cal restorative fees are also a small fraction of UCR fees. If these children had to go to a private dental facility with general anesthesia provided by a board certified anesthesiologist, they would have to pay three to five thousand dollars.

3605 HOSPITAL ROAD, SUITE H ▲ ATWATER, CALIFORNIA 95301 ▲ 209-381-2047 ▲ FAX 209-381-2045

Ned, is there any way that DHS licensing process can be accelerated? I would appreciate any help you could give me. At Central California Dental Surgicenter we have treated more than 14,000 children and developmentally disabled adults. It is very frustrating to think of not being able to treat patients until a year or more after opening.

Sincerely, Larry Church D.D.S.

Lawrence R. Church, DDS
Dental Director
Central California Dental Surgicenter

LRC/fc